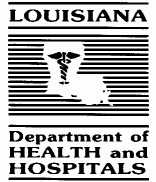




STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



**Louisiana Childhood Lead Poisoning Prevention Program (LACLPPP)  
Lead Case Reporting Form**

Copies of the following form can be used to report lead results. As stated in the Louisiana Childhood Lead Poisoning Prevention Program Rule (LAC 48:V.7001-7007), please provide all of the following information. Please print all information, use separate forms for each patient and fax the completed form to (504) 568-7722.

**PATIENT INFORMATION**

1. LAST NAME: \_\_\_\_\_ 2. FIRST: \_\_\_\_\_ 3. MI: \_\_\_\_\_  
4. SSN: \_\_\_\_\_ 5. MEDICAID NUMBER (if any): \_\_\_\_\_  
6. DATE OF BIRTH: \_\_\_\_\_ 7. SEX: FEMALE MALE  
8. RACE: Black White Other \_\_\_\_\_ 9. NATIONAL ORIGIN: \_\_\_\_\_

**PARENT'S OR GUARDIAN'S INFORMATION**

10. PARENT'S OR GUARDIAN'S FULL NAME: \_\_\_\_\_  
11. MOTHER'S FULL NAME: \_\_\_\_\_ 12. PHONE NUMBER: \_\_\_\_\_  
13. ADDRESS: \_\_\_\_\_  
14. CITY: \_\_\_\_\_ 15. STATE: \_\_\_\_\_ 16. ZIP: \_\_\_\_\_  
17. PARISH/COUNTY: \_\_\_\_\_

**BLOOD LEAD INFORMATION**

18. BLOOD LEAD RESULT: \_\_\_\_\_ 19. DATE COLLECTED: \_\_\_\_\_  
20. Please circle one: CAPILLARY VENOUS  
21. Please circle one: FIRST ANNUAL REPEAT

**REPORTING PROVIDER OR LABORATORY INFORMATION**

22. PROVIDER/LAB NAME: \_\_\_\_\_  
23. CONTACT PERSON: \_\_\_\_\_  
24. ADDRESS: \_\_\_\_\_  
25. CITY: \_\_\_\_\_ 26. STATE: \_\_\_\_\_ 27. ZIP: \_\_\_\_\_  
28. PARISH/COUNTY: \_\_\_\_\_  
29. TELEPHONE: \_\_\_\_\_ 30. FAX: \_\_\_\_\_

OFFICE OF PUBLIC HEALTH \$ LOUISIANA CHILDHOOD LEAD POISONING PREVENTION PROGRAM  
325 LOYOLA AVENUE \$ P.O. BOX 60630 \$ NEW ORLEANS, LOUISIANA 70160-0630  
PHONE#: 504/568-5070 \$ FAX#: 504/568-7722  
"AN EQUAL OPPORTUNITY EMPLOYER"